PRINTED: 04/27/2011

	T OF HEALTH AND HUN					RM APPROVED
	R MEDICARE & MEDIC  NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONETRICTION		IB NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING	00	04/07/2	
			B. WING		04/07/2	2011
NAME OF	PROVIDER OR SUPPLIER	3	STREET	ADDRESS, CITY, STATE, ZIP CODE		
			l	NDREW AVE		
BRENTWOOD AT LAPORTE		E	LA PO	RTE, IN46350		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	JATE	DATE
R0000						
	Tribin init	Ct-t- D 1 1	DOOOO	This plan of correction is not to	, ha	•
		or a State Residential	R0000	construed as an admission of or		
	Licensure Surve	у.		agreement with the findings an		
				conclusions in the Statement of		
	Survey dates: A	pril 6 & 7, 2011		Deficiencies, or the proposed		
				administrative penalty (with rig	ght to	
	Facility number:	: 010890		correct) on the community. Rat	her it	
	Provider number			is submitted as confirmation of our		
	AIM number: N			ongoing efforts to comply with all		
		77.1		statutory and regulatory		
	Curron toom:		requirements. In this document, we			
	Survey team:	N TC		have outlined specific actions i response to each allegation or	11	
	Lara Richards, R			finding. We have not presented	1 all	
	Janet Adams, R.			contrary factual or legal argum		
	Kitty Vargas, R.	N.		nor have we identified all mitig		
				factors.		
	Census bed type	:				
	Residential: 118	3				
	Total: 118	3				
	Census payor ty	ne:				
	Other: 118	r - ·				
	Total: 118					
	10141. 110					
	C1 0					
	Sample: 8					
	Th	Salara and State				
	These state findi	_				
	accordance with	410 IAC 16.2.				
	Quality review 4	4/11/11 by Suzanne				
	Williams, RN					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(k) The facility must immediately consult the resident 's physician and the resident 's legal representative when the facility has noticed: (1) a significant decline in the resident 's

> TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

R0036

Event ID:

M7W311

Facility ID:

010890

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
			B. WIN			04/07/2	011	
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER	-		2002 AI	NDREW AVE			
	OOD AT LAPORTE			LA POF	RTE, IN46350			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
		or psychosocial status; or treatment significantly, that						
	· ,	entinue an existing form of						
	treatment due to a	dverse consequences or to						
	commence a new						1	
		review and interview, the	R(	0036	Corrective Action: Resident # 1	and	05/06/2011	
	-	ensure the residents'			resident's # 4's physicians were notified of the blood pressures or			
	physician was no	tified of blood pressure			blood sugars on April 16th, 2011.			
	results and low b	lood sugars for 2 of 7			oroou ouguro orriprii rous, zorri			
	records reviewed	in the sample of 8.			How to Identify Other Residents:			
	(Residents #1 and	d #4)			Any resident with blood pressure			
					blood sugars parameters have the			
	Findings include	:			potential to be affected by this			
	C				finding.			
	1. The record for	r Resident #1 was			The Resident Care Coordinator			
	reviewed on 4/6/	11 at 1:20 p.m. The			and/or designee will audit all the			
		ses included, but was not			MAR's to check for proper physic			
	_	tension (high blood			notification to ensure compliance	e by		
		March 2011 Physician's			April 30th, 2011.			
	• ′	(POS), indicated the			Systemic Changes: Brentwood's			
	_	pressure was to be			licensed staff will follow facility			
	_	a day and the physician			policy in regards to physician			
		if the resident's blood			notification.			
	pressure was less				An in-service will be conducted or			
	F 1122 112 7 11 40 10 10 10				April 26th, 2011 with all licensed			
	The November 2	010 blood pressure			staff to review the policy and			
		indicated the resident's			procedures for physician notificat	tion.		
		ras 90/40 on 11/12, 96/50						
	•	on 11/23, and 96/54 on			Monitoring Corrective Actions:	ha		
	· ·	was no documentation in			Weekly audits of the MAR's will conducted by the Resident Care	De		
		ress Notes of the			Director to ensure physician			
		notified of the blood			notification is being completed pe	er		
		louried of the blood			our facility policy.			
	pressure.							
	Interview with th	ne Administrator on						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
			B. WING	3 <u> </u>		04/07/2	011	
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
					NDREW AVE			
BRENTV	OOD AT LAPORTE			LA POF	RTE, IN46350			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<u>'</u>	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	` ·	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		.m., indicated there was						
	no documentation	n to indicate if the						
	physician had be	en notified of the blood						
	pressure results.							
	2. The record for	Resident #4 was			Corrective Action: Resident # 1	and	05/06/2011	
	reviewed on 4/6/	11 at 12:05 p.m. The			resident's # 4's physicians were			
	resident had diag	noses that included, but			notified of the blood pressures or blood sugars on April 16th, 2011.			
	were not limited	to, diabetes, congestive			blood sugars on April Tour, 2011	•		
	heart failure and	anxiety.			How to Identify Other Resident	s:		
					Any resident with blood pressure			
	Review of the ph	ysician's order sheet,			blood sugars parameters have the			
	•	dicated the resident was			potential to be affected by this			
	•	per sliding scale three			finding.			
		sed on her blood glucose			The Resident Care Coordinator			
	reading.	S			and/or designee will audit all the			
	<i>S</i> .				MAR's to check for proper physi-			
	The physician's o	order indicated the			notification to ensure compliance	e by		
		eceive regular insulin as			April 30th, 2011.			
	follows:	coerve regular insulin as			Systemic Changes: Brentwood's			
	10110 W.S.				licensed staff will follow facility			
	Rlood alucose 0-	150 = 0 units of insulin			policy in regards to physician			
	_	51-200 = 2 units of			notification.			
	insulin	71-200 — 2 umis 01						
		01-250 = 4  units of			An in-service will be conducted of			
		71-230 – 4 units 61			April 26th, 2011 with all licensed staff to review the policy and	l		
	insulin	51 200 – Comite of			procedures for physician notificat	tion.		
	_	51-300 = 6 units of			T T T T T T T T T T T T T T T T T T T			
	insulin	01.250 0			Monitoring Corrective Actions:			
		01-350 = 8  units of			Weekly audits of the MAR's will	be		
	insulin	-1 400 0 4 2			conducted by the Resident Care			
	_	51-400 = 0 units of			Director to ensure physician notification is being completed po	er		
	insulin				our facility policy.	~-		
	_	0 give 12 units and call						
	the Doctor							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED
			B. WING			04/07/2011
			D. WING		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				NDREW AVE	
BRENTW	OOD AT LAPORTE	-			RTE, IN46350	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	The form titled, '	'Blood Glucose				
	Tracking," and d	ated March 2011 was				
	reviewed. On Ma	arch 12, 2011, before				
	breakfast, the res	ident's blood glucose was				
		e 65-110). There was no				
		the record that the				
		otified of the low blood				
	glucose reading.	or the form blood				
	gracose reading.					
	On March 25, 20	11, the resident's blood				
	·					
	_	was 48 before breakfast.				
	There was no do					
		tified of the low blood				
	glucose reading.					
	The policy titled	"Blood Glucosa				
		a revision date of				
	_					
	•	vided by the Resident				
		4/6/11 at 1:15 p.m. She				
	-	icy was current. The				
		"Licensed staff should				
	report significant	t changes in blood				
	glucose reading a	according to parameters				
	to physician."					
	Interview with th	ne Resident Care Director				
	on 4/6/11 at 1:55	p.m. indicated the				
	physician should	be notified when a				
		glucose reading is below				
	_	I the resident's physician				
		of the low blood glucose				
		ch 12 and March 25,				
	2011.	12 und muron 23,				
	2011.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON			NSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED
			B. WIN			04/07/2	011
NAME OF D	DOVIDED OD SLIDDLIED		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				2002 Af	NDREW AVE		
	OOD AT LAPORTE			LA POF	RTE, IN46350		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		iew with the Resident					
	Care Director on	4/6/11 at 2:25 p.m.					
	indicated Reside	nt #4's physician was					
	contacted on 4/6/	11. The physician gave					
	orders that he is	to be notified of any					
	blood glucose rea	•					
	orood gracose rec	ading below 70.					
R0120	(e) There shall be	an organized inservice					
K0120		ning program planned in					
		rsonnel in all departments					
	•	Training shall include, but is					
		dents' rights, prevention and					
		, fire prevention, safety,					
		n, the needs of specialized					
	populations served	d, medication d nursing care, when					
	appropriate, as fol						
		and content of inservice					
		ning programs shall be in					
		ne skills and knowledge of					
	the facility personr	nel. For nursing personnel,					
		it least eight (8) hours of					
		ndar year and four (4) hours					
		lendar year for nonnursing					
	personnel.	ne above required inservice					
		ave contact with residents					
		num of six (6) hours of					
		training within six (6)					
	months and three	(3) hours annually					
		the needs or preferences,					
		rely impaired residents					
		gain understanding of the					
	dementia.	of care for residents with					
		ds shall be maintained and					
	shall indicate the f						
	(A) The time, date	_					
	(B) The name of the						
	(C) The title of the	instructor.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/07/2011	
NAME OF PROVIDER OR SUPPLIER  BRENTWOOD AT LAPORTE			2002 A	ADDRESS, CITY, STATE, ZIP CODE NDREW AVE RTE, IN46350			
SUMMARY STATEM (EACH DEFICIENCY MU REGULATORY OR LSC ID  (D) The names of the pa (E) The program conter The employee will ackn by written signature. Based on record revier facility failed to ensur hours of required dem training inservices we 38 current employees This deficient practice affect 118 residents wi facility. (Employees # 1, #2, #  Findings include:  The facility employee training records were at 10:00 a.m. The following employ completed the required dementia specific train through 12/31/10:  Employee #1 - CNA h Employee #4 - CNA h Employee #5- CNA h	to finservice. bwledge attendance w and interview, the e the annual three entia specific re provided to 6 of hired before 1/1/10. had the potential to ho resided in the 4, #5, #6, and #7)  files and inservice reviewed on 4/7/11 ees had not d three hours of hing during 1/1/10  ired on 11/23/09 7 Wait Staff hired on ired on 11/17/07		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)  Corrective Action: All employed who have been identified during survey will complete the 3 hour dementia training by May 6th, 2  How to Identify Other Resident No residents were affected. All Employees' in service records we audited by the Business Office Director and/or designee to ensure compliance by April 23rd, 2011  Any Employee not in compliance will have the dementia training completed by May 6th, 2011.  Systemic Changes: An in service schedule is in place to ensure all meet the 3 hour dementia training year requirement.  Monitoring Corrective Actions The Business Office Director ard designee will track attendance a each scheduled in service to ensure designee will track attendance are ach scheduled in service to ensure of the schedule until the required in services are completed.	ees g the 2011.  Ats:  vill be are  cee l staff ag per  s: ad /or t t aure t of	(X5) COMPLETION DATE  05/06/2011	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/07/2011
		STREET 2002 A	NDREW AVE	
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
hours of dementi have been compl	a specific training should eted for all employees			
accurate personner The personnel recinclude the following (1) The name and (2) Social Security (3) Date of beginn (4) Past employment education, if applied (5) Professional liconumber or dining a of completion, if all (6) Position in the (7) Documentation facility, including respecific job skills. (8) Signed acknown residents' rights. (9) Performance ewith facility policy. (10) Date and reast Based on recording facility failed to corientation was demployee recording specific orientation. This deficient proaffect 118 resident facility. (Employees #8, #	el records for all employees. Fords for all employees shall and: Fords for all employees shall address of the employee. For number. For nu	R0123	Corrective Action: The 3 emplose identified during the survey have had a job specific orientation completed with them by the Resi Care Director and/or designee by April 30th, 2011.  How to Identify Other Resident No residents were affected. All Employees' files will be audited ensure compliance by April 23rd 2011 by the Business Office Director.	ident  ts:
Findings include	:		2011 by the Business Office Dire	
	CONTRECTION  PROVIDER OR SUPPLIER  SUMMARY S'  (EACH DEFICIENT REGULATORY OR  the facility Admit hours of dementithave been completed who had worked  (h) The facility shate accurate personnel recincled the following (1) The name and (2) Social Security (3) Date of beginn (4) Past employment education, if applied (5) Professional licunumber or dining a of completion, if applied (6) Position in the (7) Documentation facility, including respecific job skills. (8) Signed acknown residents' rights. (9) Performance ewith facility policy. (10) Date and reason Based on record and the content of the content	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  the facility Administrator indicated three hours of dementia specific training should have been completed for all employees who had worked through 2010.  (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure job specific orientation was completed for 3 of 5 employee records reviewed for job specific orientation at the time of hire. This deficient practice had the potential to affect 118 residents residing in the	ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The facility Administrator indicated three hours of dementia specific training should have been completed for all employees who had worked through 2010.  (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation.  Based on record review and interview, the facility failed to ensure job specific orientation was completed for 3 of 5 employee records reviewed for job specific orientation at the time of hire.  This deficient practice had the potential to affect 118 residents residing in the facility. (Employees #8, #9, and #10)	PROVIDER OR SUPPLIER  ### JOOD AT LAPORTE    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    The facility Administrator indicated three hours of dementia specific training should have been completed for all employees who had worked through 2010.    (h) The facility shall maintain current and accurate personnel records for all employees who had worked through 2010.    (h) The mame and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure job specific orientation as the time of hire. This deficient practice had the potential to affect 118 residents residing in the facility. (Employees #8, #9, and #10)    WIND   STREET ADDRESS, CITY, STATE, ZIP CODE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M7W311 Facility ID:

010890

If continuation sheet

Page 7 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  . DUE DUE 00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			04/07/2011	
			B. WING			04/07/20	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
DDENITA	VOOD AT LAPORTE	-			IDREW AVE TE, IN46350		
					.1E, 1140330		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	- 1	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL	PREF	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAC	G	and/or designee.		DATE
	TEN 6 111	1			and/or designee.		
	1	loyee records were					
		11 at 10:00 a.m. There					
		tation of job specific			Systemic Changes:		
	orientation being	provided to the			Any employee who does not have		
	following employ	yees:			completed job specific orientation		
					1 2	1ay	
	Employee #8- L	PN hired on 12/2/10			6th, 2011.		
	Employee #9- Q	MA hired on 2/9/11			<b>Monitoring Corrective Actions:</b>		
Employee #10- CNA hired on 2/9/11				The Business Office Director will			
				ensure a completed job description			
	   When interviewe	ed on 4/7/11 at 12:25			completed and filed in the		
		Administrator indicated			Employees' file on every new hir	e.	
	<sup>-</sup>	cific orientation for the				.,	
	l " '				The Business Office Director and		
	1	s was not available in the			designee will audit all new Emplo files and will present the findings	-	
	employee record	S.			during the monthly Quality	'	
					Assurance meetings to ensure 100	0%	
					compliance ongoing.		
ı ı							
R0144		all be clean, orderly, and in a					
	state of good repair, both inside and out, and shall provide reasonable comfort for all						
	residents.	Shable connection all					
	Based on observa	ation and interview, the	R0144	.	Corrective Action: The walls an	d	05/06/2011
	facility failed to	· ·			doors in the Memory Care		
		ted to marred walls and			Neighborhood that needed to be		
		nory Care Unit. This had			touched up will be painted by Ap	ril	
		ffect 33 of 33 residents			23rd, 2011.		
	_	emory Care Unit.			How to Identify Other Resident	s:	
	Tosiding in the M	emory care out.			No residents were affected.		
	Findings include	:			0 4 0 0 41 00 41	,	
	<i>G</i> 2				<b>Systemic Changes</b> : All staff will in serviced on how to inform the	be	
	   1 During the env	vironmental tour, on			Environmental Supervisor what is	, l	
	_	n., with the Maintenance			the community needs attention, si		
		ii., with the manitumance	<u> </u>		as marred walls and doors by Apr		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  04/07/2011	
	PROVIDER OR SUPPLIER		2002 A	ADDRESS, CITY, STATE, ZIP CODE ANDREW AVE RTE, IN46350	04/01/2011
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG		LSC IDENTIFYING INFORMATION) owing was observed:	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  28th, 2011.	DATE
	a. 3 of 4 walls in Memory Care Ur mars. The walls we three feet of the value of paint. He are as on the second of the bottom 12 on the bottom	the dining room in the nit had black marks and were marred on the lower walls.  door in room 402 had be bottom 12 inches.  y bathroom door had bottom 12 inches.  om 405 had black areas inches.  om 410 had black areas inches.  e Maintenance Director environmental tour, above areas in the nit were marred and in sindicated the marred were due to walkers and		Monitoring Corrective Actions The Environmental Supervisor be responsible for sustained compliance by completing environmental rounds of the community and reporting finding the Quality Assurance Committed monthly. Page one of the Environmental section of the Comprehensive Process Review be used to conduct the rounds of community.	egs to ee
R0217	facility, using appr members, shall ide services to be pro- follows:	pletion of an evaluation, the opriately trained staff entify and document the vided by the facility, as ffered to the individual appropriate to the:			

010890

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
			B. WING		04/07/2011
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
DDENTA	ACCD AT LABORTE	-	I	NDREW AVE	
	OOD AT LAPORTE	-	LAPO	RTE, IN46350	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	and revised as application that the resident and factorized in the request a service plant and dated of the service plant resident upon requestion of the services provided subsequent to the no need for a chara (5) If administration provision of reside both, is needed, a involved in identification of the services to be a large of the services of the services to be a large of the services of the s	on service plan shall be by the resident, and a copy is shall be given to the uest. In and documentation of its needed if evaluations initial evaluation indicate age in services. In of medications or the ential nursing services, or licensed nurse shall be cation and documentation be provided. In review and interview, the ensure service plans were by the resident, for 1 of ed, in a sample of 8.	R0217	Corrective Action: Resident #4's service plan has been reviewed ar signed with the resident on 4/6/20  How to Identify Other Residents All residents who reside in Brentwood's Assisted Living or Memory Care Neighborhood have the potential to be affected by this finding	ob/06/2011 011. s:
		esident #4 was reviewed		finding.	
	admitted to the fa	5 p.m. The resident was acility on 2/14/11 and had cluded, but were not es, congestive heart ty.		The Resident Care Director and/or designee will complete an audit of the residents who currently reside the assisted living and memory can eighborhood to ensure that they signed by the resident and/or fam by April 30th, 2011.	f all in ire are

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010890

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/07/2011	
	PROVIDER OR SUPPLIER  OOD AT LAPORTE		STREET A 2002 A	ADDRESS, CITY, STATE, ZIP CODE NDREW AVE RTE, IN46350	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	completed by the on 3/16/11. The I had signed the se form 3/16/11. Re indicated the residated the form.  Interview with tho on 4/6/11 at 1:30 resident was alert capable of signinalso indicated the not on the service.  Interview with the 2:15 p.m., indicated the control of the services the services of	Resident Care Director Resident Care Director rvice plan and dated the view of the service plan dent had not signed and  e Resident Care Director p.m., indicated the and oriented and was g the service plan. She e resident's signature was e plan.  e resident on 4/6/11 at ted the resident did not ag in her service plan.		Systemic Changes: The Resider Care Coordinator will be respons to ensure all service plans are sign by the resident and/or family afte completion of any assessment.  Monitoring Corrective Action: Random audits of the resident records will be completed by the Resident Care Director and/or designee monthly and the finding will be reported to the Quality Assurance Committee to ensure compliance.	ible ned r
R0306	shall be disposed appropriate federa disposition of any destroyed medicat the resident 's clir include the followin (1) The name of th (2) The name and (3) The prescriptio (4) The reason for (5) The amount dis (6) The method of (7) The date of the (8) The signature of the disposal of the	I, state, and local laws, and released, returned, or ion shall be documented in iocal record and shalling information: ie resident. strength of the drug. n number. disposal. sposed of. disposition. e disposal. of the person conducting			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 04/07/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2002 ANDREW AVE **BRENTWOOD AT LAPORTE** LA PORTE, IN46350 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE disposal of the drug. Corrective Action: Resident # 6 was R0306 05/06/2011 Based on record review and interview, the discharged in February from facility failed to ensure a medication Brentwood. disposition form had been completed for 1 of 2 closed records reviewed in the **How to Identify Other Residents:** sample of 8. (Resident #6) Any resident who has their medications administrated by the licensed staff at Brentwood and has Findings include: been discharged has the potential to be affected by this finding. The record for Resident #6 was reviewed on 4/6/11 at 10:30 a.m. Review of the Systemic Changes: The Resident Care Director and/or designee will be March 2011 Physician's Order Summary responsible to ensure that any (POS), indicated the resident received resident who has their medication Lasix (a water pill) 20 milligrams (mg) administered by the licensed staff daily and Nitroglycerine ER (a heart and is discharged, has a record of medication) 2.5 mg twice a day. The medication disposition form completed at the time of discharge. resident expired at the facility on 3/8/11. A medication disposition form was not **Monitoring Corrective Actions:** available for review. Chart audits of residents who have been discharged from the community Interview with the Administrator on will be completed by the Resident Care Director and/or designee. The 4/7/11 at 10:00 a.m., indicated a findings will be reported in the medication disposition form had not been monthly Quality Assurance completed. Committee to ensure compliance.

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